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# Commentary

## TAX-EXEMPTION FOR HOSPITALS: TOWARDS AN UNDERSTANDING OF COMMUNITY BENEFIT

*J. David Seay, J.D.†*

THE CURRENT legal and public policy debate about the charitable status of voluntary not-for-profit hospitals, which most often takes the form of challenges to tax-exempt status,<sup>1</sup> can be viewed as a debate about accountability. This debate takes on a heightened urgency against the backdrop of a decade of continually rising health care costs and the growing number of Americans with no health insurance coverage. With a federal government paralyzed by a lack of leadership on fundamental issues of national health policy, and with politicians seized with the fervor of a free market and "pro competition" ideology, now generally discredited by many observers, hospitals are being closely examined for the extent of their charitable services, with a particular emphasis on the provision of uncompensated services to the poor. Furthermore, there appears to be a growing fascination with the use of the tax code to solve national health care access problems.<sup>2</sup>

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1. *Utah County v. Intermountain Health Care, Inc.*, 709 P. 2d 265 (Utah 1985). *Medical Ctr. Hosp. of Vt., Inc. v. Burlington*, 566 A2d 1352 (Vt. 1989); *Downtown Hosp. Ass'n v. Tenn. State Bd. of Equalization*, 760 S.W. 2d 954 (Tenn. App. 1988); *St. Luke's Hosp. v. Bd. of Assessment Appeals*, No. 88-C-2691 (Pa. Ct. C.P., Lehigh Co., April 19, 1990). *See also*, *State v. Methodist Hosp. Sys.*, No. 494,212 (126th J. Dist. Travis Co., Tex., filed Nov. 26, 1990), *In re HealthEast, Inc.*, No. 198801297 (Pa. Ct. C.P., Orph. Ct. Div., Lehigh Co., July 12, 1990). For a discussion of the Texas Attorney General's attack on the tax exemption of Houston's Methodist Hospital, *see* Gary Taylor, *Charity Begins in Court? Hospital Sued in Novel Lawsuit*, NAT'L L.J., Feb. 18, 1991 at 3.

2. H.R. 790, 102d Cong., 1st Sess. (1991); H.R. 1374, 102d Cong., 1st Sess. (1991); U.S. GENERAL ACCOUNTING OFFICE, *NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION* 27 (1990); Robert Pear, *Bush's Plan and I.R.S. at Odds on Health*

In analyzing the positions taken by the various parties to this debate, it is important that there be a clear understanding of what the standards for tax-exemption are, and more importantly, why we grant tax-exempt status in the first place. Only then will we be able to determine whether tax policy is broken, and if so, how it should be fixed.

In commenting on "The Future of Tax-Exemption for Non-Profit Hospitals and Other Health Care Providers" by Professor John D. Colombo and Professor Mark A. Hall, I will argue that as important as public perceptions are, and as valued as outcomes of institutional behavior might be, the standard for tax-exemption for hospitals—community benefit—derives its criteria from expectations about organizational processes and how institutions are governed and managed.<sup>3</sup> Further, I argue that the underlying policy rationale and intent for granting tax-exempt status is to encourage certain types of organizations and institutions rather than to stimulate, through indirect subsidy, specific and mathematically quantifiable solutions to identified social problems.

## TWO OUT OF THREE

In the article, Colombo and Hall set out to do three things. First, they seek to provide an overview of the background of the hospital tax-exemption issue and to explain how it has become such a front-burner issue on today's health care and tax policy scene. In doing so, they also review current tax-exemption standards at the state and federal levels, in an effort to set the groundwork for their legislative analysis and policy argument.

Second, they strive to undertake a careful analysis of the two legislative proposals recently submitted in the United States House of Representatives by Congressmen Brian J. Donnelly of Massachusetts<sup>4</sup> and Edward R. Roybal of California.<sup>5</sup> These bills, which seek

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Care, N.Y. TIMES, Feb. 9, 1992 at Y14 (I.R.S. rulings on tax status of health maintenance organizations clash with Bush Administration health reform policy).

3. J. David Seay, *Community Benefit Prevails*, HEALTH PROGRESS (Jan.-Feb. 1992); J. David Seay, *Hospitals' Predicament May Be all Non-profits'*, THE CHRON. OF PHILANTHROPY, Nov. 19, 1991 at 42,43; *The Tax-Exempt Status of Hospitals, Hearings on H.R. 1374 Before the House Committee on Ways and Means*, 102d Cong., 1st Sess. (1991) (statement of J. David Seay), reprinted in *Testimony of J. David Seay, Vice President, Secretary and Counsel, United Hospital Fund of New York, Before the Committee on Ways and Means, United States House of Representatives, July 19, 1991*, 4 EXEMPT ORG. TAX REV. 639-641 (1991) [hereinafter *The Tax-Exempt Status of Hospitals*].

4. H.R. 1374, 102d Cong., 1st Sess. (1991).

5. H.R. 790, 102d Cong., 1st Sess. (1991). It should be noted that Congressmen Don-

to set clearer standards by which hospitals are granted or allowed to retain tax-exempt status for Federal income tax purposes, take different definitional and enforcement approaches to the issue. However, both rely upon a "relief of poverty" rationale for defining charitable purpose.

Finally, Colombo and Hall argue again for their "donative theory" or "market in altruism" rationale for tax-exemption.<sup>6</sup>

In commenting on the authors' success in achieving their objectives, I suppose that two out of three is not bad. They are succinct in their overview of the tax-exemption issue; detailed and rather enlightening in their legislative analysis, although I differ with them on some of their analytic tools; but they offer disappointingly little new insight when they conclude with their plea for their version of Hansmann's "donative theory," which I refer to as the "popularity contest" rationale for tax-exemption.

#### BACKGROUND: A MATTER OF EMPHASIS

In analyzing the Internal Revenue Service's treatment of hospital tax-exemption, Colombo and Hall curiously emphasize the "promotion of health" portion of the clause contained in the 1969 Revenue Ruling 69-545 and almost entirely ignore the portion of the clause in that same ruling that speaks to the "benefit of the general community."<sup>7</sup> This is important to note, for it is the language that revives the centuries old "community benefit" standard, dating back at least to the English Statute of Charitable Uses in 1601,<sup>8</sup> later so brilliantly restated by Lord McNaughten in *Pemsel's* case,<sup>9</sup> and quoted again more recently by Chief Justice Burger of the United States Supreme Court in 1983.<sup>10</sup>

The most important concept behind the community benefit notion, which apparently Colombo and Hall fail to see, is that hospi-

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nelly and Roybal plan to retire at the end of the current term. Adam Clymer, *Citing Rise in Frustration, Dozens of Lawmakers Quit*, N.Y. TIMES, April 5, 1992 at 1.

6. Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307-411 (1991); Mark A. Hall & John D. Colombo, *The Donative Theory of the Charitable Tax Exception*, 53 OHIO ST. L.J. 1, 14-25 (1992); Mark A. Hall, Address at the New York Univ. School of Law (October 10-11, 1991).

7. Rev. Rul. 69-545, 1969-2 C.B. 117.

8. An Act To Redress the Misemployment of Lands, Goods and Stocks of Money Heretofore Given to Certain Charitable Uses (Statute of Charitable Uses), 1601, 43 Eliz. ch. 4.

9. *Commissioners v. Pemsel*, 1891 App. Cas. 531, 583 (H.L.).

10. *Bob Jones Univ. v. United States*, 461 U.S. 574, 588 (1983).

tals or other health care institutions, or for that matter any number of other types of socially beneficial institutions, derive their rationale for tax-exemption not from the promotion of health, or the promotion of culture or music, or social welfare; but rather, and more importantly, from providing socially desirable benefits in a particular way to the larger community as a whole.<sup>11</sup> This assumes, of course, that all of the other criteria regarding non-profit organizations are met, e.g. the "non-distribution constraint," incorporation under a not-for-profit corporation law, and prohibitions against private inurement, private benefit, involvement in political activities and substantial lobbying efforts.<sup>12</sup>

This distinction between "promotion of health" and providing "community benefits" is important for purposes of this debate. If we are to narrow the scope of the tax-exemption standard and be more restrictive in the granting of tax-exempt status, as many argue that we should, then we should be exacting and explicit in choosing which of these two policy rationales we use in crafting new policy and in drafting new tax legislation. By assuming the "promotion of health" as the rationale for tax-exemption, Colombo and Hall are inextricably driven to the conclusion that tax-exempt status for hospitals must be awarded or denied on the basis of the extent to which they provide free or uncompensated health care services to the poor.

To the contrary, the more historically consistent understanding of the community benefit concept is that we provide tax-exempt status to encourage institutions and organizations such as hospitals, essentially voluntary in nature, which are governed and managed in a manner beneficial to the community.<sup>13</sup> If the current laws are deficient, as I believe they are, they are not so because they fail to dictate specific outcome levels of charity care provision, but rather, because they are not clear enough or do not go far enough in providing guidelines or criteria about the nature of these institutional

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11. Rev. Rul. 69-545, 1969-2 C.B. 117; Carl T. Schramm, *The Legal Identity of the Modern Hospital: A Story of Evolving Values*, in *IN SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS* 65-86 (J. David Seay & Bruce C. Vladeck eds., 1988).

12. I.R.C. § 501 (c) (3); *Better Business Bureau v. United States*, 326 U.S. 283 (1945); *Simon v. Eastern Ky. Welfare Rights Org.*, 426 U.S. 26 (1976); *Bob Jones Univ. v. United States*, 461 U.S. at 588.

13. Robert M. Sigmond, Address at Park Ridge Hospital, Rochester Area Hospital Council, William B. Woods Memorial Lecture (October 22, 1981); Robert M. Sigmond, Address at Graduate School of Business, University of Chicago, Center for Health Administration Studies Michael M. Davis Memorial Lecture (May 10, 1985); J. David Seay & Robert M. Sigmond, *Community Benefit Standards for Hospitals: Perceptions and Performance*, *FRONTIERS OF HEALTH SERVICES MGMT.*, Spr. 1989, at 3.

governance and management processes to which these institutions should be held more accountable.

### THE LEGISLATIVE ANALYSIS

Colombo and Hall do a great service in their analysis of the legislative proposals of Congressmen Donnelly and Roybal, to the extent that they point out in detail the quagmires of complexity into which hospital trustees and managers, as well as IRS officials, would be pushed were these proposals adopted. They are similarly informative in pointing out the definitional differences between the two bills with regard to what constitutes hospital charity care costs. Furthermore, they correctly emphasize the need for intermediate sanctions, short of revocation of exempt status, for those hospitals failing to meet one or more of the criteria. Of course this begs the question as to which standards should be employed in an effort to firm-up the community benefit notion.

However, the authors are correct to note that there appears to be a growing consensus that the operation of an emergency room and the existence of a Medicaid provider agreement should be added to the extant procedural or "process" criteria now employed for tax-exemption.<sup>14</sup>

However, in their commentary on the exemption standards, Colombo and Hall use their "relief of government burden" or *quid pro quo* theory as an analytic tool, particularly in their analysis of the Roybal bill. I must comment that although the "relief of government burden" theory is one of a number of policy rationales enunciated over the years in the case law of tax-exemption, as Guggenheimer has emphasized,<sup>15</sup> it is but one theory. It is also one with serious empirical shortcomings with regard to the expectations and the behavior of the American people.

For example, Colombo and Hall say that ". . .this theory posits that exemption is warranted because, in the absence of the exemption, government *would have to pay for* services rendered by the exempt entity" (emphasis added).<sup>16</sup> Although they argue that the

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14. This was made clear repeatedly by witnesses testifying on July 10th, 1991, before the Ways and Means Committee in its hearings on hospital tax-exempt status. See *The Tax-Exempt Status of Hospitals*, *supra* note 30.

15. Elizabeth M. Guggenheimer, *Making the Case for Voluntary Health Care Institutions: Policy Theories and Legal Approaches*, in *IN SICKNESS AND IN HEALTH*, *supra* note 11, at 35.

16. John D. Colombo & Mark A. Hall, *The Future of Tax Exemption for Nonprofit Hospitals and Other Health Care Providers*, 2 *HEALTH MATRIX* 1, 14 (1992) [hereinafter *Colombo & Hall*].

provision of health services to those unable to pay would more logically be accomplished by direct government subsidy than by indirect subsidy through tax-exemption, they nonetheless enthusiastically adopt the *quid pro quo* or "relief of government burden" rationale essentially by asking the question: why shouldn't a hospital earn its tax-exemption? A fair question.

Regrettable as it is, health care is not a right in America, nor has the government even enunciated its intention to assure the provision of hospital services to each and every one of America's inhabitants. If anything, the Federal government has been decreasing its direct involvement in the operation of hospitals and the provision of health service. The fewer voluntary hospitals there are will simply mean fewer hospital services provided. There is no indication that the government will pick up the slack. Empirically, at least, the "relief of government burden" rationale is a poor analytic tool and a slender reed at best.

The fault that the authors find with the Roybal bill is not that it attempts to measure the wrong thing, which it does. In fact, it is clear that they believe that charity care *is* the one true way to measure community benefit. Their problem with the proposal is that it does not compare voluntary to for-profit-hospitals. Indeed they quite logically observe that ". . . if exempt hospitals do not have proportionately more uncompensated care than for-profit hospitals, then the exempt hospitals in fact are not relieving any government burden and do not deserve exemption under this theory."<sup>17</sup> Again, once one accepts as a premise the notion that the community benefit theory requires as its measure the provision of uncompensated care services to the poor, then theirs would be a logical result. I think this is a false premise, and that the Roybal bill, along with Professors Colombo and Hall, are simply attempting to measure the wrong thing.

Similar analytic tools are used to examine the Donnelly bill. However, Colombo and Hall offer two enlightening observations. First, they observe that about the only type of hospital which is sure not to meet the tax-exemption test of the Donnelly bill are the specialty hospitals. These institutions, although exempt from the requirement of operating an emergency room under the bill, would not be exempt from the five-part alternative test for community benefit.<sup>18</sup> Since specialty hospitals are likely neither to have a dis-

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17. See *id.* at 15.

18. In addition to having an emergency room open to all without regard to their ability

proportionate number of low-income Medicare and Medicaid patients nor to fit the definition of sole community hospital under the Medicare laws, and because these hospitals may not fall within the one-standard-deviation test of the Donnelly bill, specialty hospitals must achieve their tax-exempt status by either the 5% or 10% charity care expenditure test. Since the 10% test relies upon outpatient services, not often provided in great quantity by specialty institutions, then these hospitals would almost certainly be left to face the most rigorous of the five tests in order to retain or obtain tax-exempt status. Surely the specialty hospitals, and perhaps Congressman Donnelly, owe Professors Colombo and Hall a debt of gratitude for this important observation.

The second thing that the authors observe in analyzing the Donnelly bill is somewhat indirect. What they mean to be a criticism of the bill, turns out to be a flaw in common both to the bill and to the commentators' analysis, and in fact helps me make my point. Here the authors criticize the second use of the disproportionate share cost calculation in the Donnelly five-point alternative test. This calculation exempts hospitals whose disproportionate share calculation is no more than one standard deviation below the area-wide mean. Colombo and Hall argue that because this alternative test is such a large loophole, and in fact they cite an American Hospital Association estimate that over three-quarters of non-profit hospitals would pass this test, the actual rigor of the entire bill is really illusory and that the net effect is to return right back to the *status quo* for most hospitals; that is, the present fuzzy and ill-defined community benefit test. According to my analysis, this is not necessarily such a bad thing; it gets us back to the central question of how to better understand the community benefit concept. The Colombo and Hall critique of the Donnelly legislation, much like their analysis of the Roybal bill, falls into the trap—as do Donnelly and Roybal themselves—of attempting to measure the wrong thing.

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to pay, and having a provider agreement to treat Medicaid patients, in order to be tax-exempt under the Donnelly bill, a nonprofit hospital must also meet at least *one* of the following five alternative tests for community benefit: the hospital is (i) a sole community provider under Medicare, (ii) serves a disproportionate number of Medicaid or poor Medicare patients, (iii) carries a "disproportionate patient percentage" (according to the Medicare reimbursement regulations) which is within one standard deviation of the mean for all of the hospitals in the instant hospital's area, (iv) able to demonstrate that at least 5% of its gross revenues are dedicated to charity care, or (v) able to demonstrate that at least 10% of its gross revenues are dedicated to certain ambulatory care services in medically underserved areas. See *supra* note 4; see also Thomas R. Barker, *Reexamining the 501(c)(3) Exemption of Hospitals as Charitable Organizations*, 49 TAX NOTES 339 (July 16, 1990) (Barker is legislative director for Congressman Donnelly).



Two other areas applicable to both pieces of proposed legislation, where Colombo and Hall are particularly helpful, include classification and enforcement. With regard to classification, they point out that both bills' penalties would affect the tax-exempt status not only of the hospital failing the respective tests, but would also automatically jeopardize the tax-exemption of any parent or sponsoring entity which operates the hospital. This could provide obviously serious, if unintended, consequences for colleges and universities. It would almost certainly raise First Amendment concerns in instances where the hospital in question is operated by a church or other religious order. At the very least, these provisions require scrutiny and reconsideration.

In analyzing the enforcement provisions of the proposed bills, the authors note the excise tax penalty of the Roybal bill, and the curiously unique requirement that amounts collected by the IRS under the provision be paid over to the state in which the offending hospital operates. They raise, but do not explore, the ramifications of this novel approach.

Under the Donnelly bill, the authors note a continued reliance upon the revocation of exemption as the principle method of enforcement, although they correctly point out a few modifications to that concept. The authors' analysis reveals that the Donnelly bill, unsure on which way to go, provides both for a two-year period after which a hospital may be able to reclaim its tax-exempt status, and upon some notions of a penalty tax that would generally equal the difference between 10% of the hospital's gross revenues and the amount of charity care provided by the hospital. Colombo and Hall are correct in that it might be better to pick one or the other approach. Unfortunately, in my opinion, they select the wrong one in that they suggest that excise tax provisions similar to those used for private foundations be adopted as penalties under the section of the Internal Revenue Code.<sup>19</sup> Under the governance or "process standard" approach, a better penalty might be one that provides offending hospitals with an identification of any deficiencies in their processes to provide community benefit, and then provides a period of time within which to cure the alleged deficiencies. Outright revocation of exemption could be retained as a last-resort penalty.

### THE POPULARITY CONTEST

In the policy analysis section of their article, Colombo and Hall

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19. I.R.C. §§ 4940-4948.

argue not for a charity care standard for hospital tax-exempt status, but rather for their "market in altruism" approach. This notion is really an interpretation of Hansmann's "donative theory" of nonprofits.<sup>20</sup>

This notion argues that the American public can "vote with their feet" with respect to charitable organizations, and simply choose not to give contributions to those organizations that do not behave in a charitable fashion. In this manner organizations are, or can be, charitable only to the extent that the public, or some portion thereof, perceives them to be. This curious notion is neither an outcomes measure—that is, one that looks to see how much of a particular good, such as charity care, a hospital actually provides—nor a process based standard—that is, one that seeks to set the parameters of the types of organizational structure, governance, and management which society desires to encourage. It borrows upon Hansmann's notion of a dichotomy between those nonprofit organizations which are commercial in nature, and hence not deserving of tax-exempt favoritism, and those that are "donative" in nature, in that they receive a substantial proportion of their revenues from charitable contributions.<sup>21</sup> Only these latter types are "true" charities and deserve the special treatment of tax exempt status. So, the Colombo and Hall idea is nothing new. They simply take Hansmann's theory to its logical conclusion, adding along the way an arbitrary minimum amount—30%—of a hospital's revenues which must be derived from donations in order to be deemed charitable.

Even as they introduce this idea, the authors question whether tax legislation is the best route to solving our nation's major health policy concerns, e.g., access to health care services. To their credit, Colombo and Hall answer this question in the negative and conclude that tax reform is at most a second-best alternative for fundamental reform of the way in which we attempt to provide access to health care services to our nation's inhabitants. However, I think the authors have reached this conclusion for entirely the wrong reason.

The analysis used by Colombo and Hall in reaching this conclusion relies principally upon viewing the tax-exemption phenomenon as an intentional government subsidy of the private voluntary hospitals to provide health care services to the poor. I would suggest that

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20. Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835 (1980).

21. *Id.*

this was not at all the reason why hospitals were exempt from taxation in the first place, nor is it a cogent reason for exempting them now. Even though a tax-exemption undoubtedly has an effect similar to an indirect subsidy, that is not why hospitals were exempted.<sup>22</sup> As Swords has pointed out, hospitals were never conceived of being in the tax base in the first place.<sup>23</sup> Hospitals were exempt from various taxes long before there was a personal income tax<sup>24</sup> in this country, and were of a class of institutions that were deemed, but their voluntary formation and charitable nature, to be outside the revenue and property base upon which taxes were eventually applied. In this sense, Surrey's notion of a "tax-expenditure"<sup>25</sup> should have no applicability in the case of the voluntary hospital.

In hearings before the Ways and Means Committee on July 10, 1991,<sup>26</sup> many witnesses testified that Congressman Donnelly's legislative proposal would not come close to solving the formidable health care access problem in the United States. Congressman Donnelly, clearly exasperated by this, repeatedly stated that this was not the intention of his legislation. His bill was not meant to force the voluntary hospital sector to do indirectly what the government clearly has not been willing to do directly, that is, provide a national health insurance mechanism. On the other hand, he said that his bill was simply intended to provide better criteria for determining which hospitals should be exempt from taxation and which ones should not.<sup>27</sup> This is precisely what tax legislation in this area should do, and not much more.

Tinkering with Federal tax policy and the Internal Revenue Code cannot magically solve all of our social ills and shortcomings. All-too-often the argument is made that hospitals should solve the

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22. James J. McCormack, *Hospital Strategy and Public Policy: Seeking the 'Just Right' Balance*, in IN SICKNESS AND IN HEALTH, *supra* note 11, at 117; Stanley B. Jones & Merlin K. Du Val, *What Distinguishes the Voluntary Hospital in an Increasingly Commercial Health Care Environment?* in IN SICKNESS AND IN HEALTH, *supra* note 11, at 201.

23. Peter Swords, testimony before the Committee on Ways and Means, N.Y. State Assembly (March 12, 1990); and CHARITABLE REAL PROPERTY TAX EXEMPTIONS IN NEW YORK STATE (1981).

24. Rev. Act of 1894 (Act of August 15, 1894, Ch. 349, 28 Stat. 553). For a discussion regarding the development of the federal charity exemption, see Kenneth Liles and Cynthia Blum, *Development of the Federal Tax Treatment of Charities*, 39 LAW AND CONTEMP. PROBS. 6 (1975).

25. STANLEY S. SURREY, *PATHWAYS TO TAX REFORM*, 34 (1973); STANLEY S. SURREY & PAUL R. MCDANIEL, *TAX EXPENDITURES*, 72-83 (1985).

26. *Supra* note 15.

27. *Id.*

health care access problem as a *quid pro quo* for their tax-exemption. It may be easier instead for hospitals to convert to for-profit status, avoid the social expectations, and be subject to taxation. They probably wouldn't pay any taxes if they did, given payment reductions, the flexibility of generally accepted accounting practices, and the ingenuity of many hospital accountants, lawyers, and consultants. As Vladeck has suggested, perhaps the tax returns of the for-profit hospital chains over the past few years should be examined by way of enlightenment in this regard.<sup>28</sup>

As Congressman Donnelly has suggested, tax-exemption is a threshold standard like most government standards. The criteria used in determining which hospitals meet this threshold should be, by their very nature, minimal tests. For those desiring higher standards and seeking to identify the very best hospitals, one should look to the private sector with its long history of very high yet flexible certification and accreditation standards. In fact, as described by Kovner and Hattis,<sup>29</sup> there is an important national demonstration project being undertaken at this time to establish and test voluntary accreditation standards for the purpose of determining community benefit among hospitals. But that is not what the tax-exemption standards are all about, nor should they be.

### MEASURING THE RIGHT THING

What is unique about voluntary organizations consists in their governance and management, and in their very voluntariness.<sup>30</sup> They are unique because they are structured in a way that is neither wholly public nor wholly private. They are private in the sense that they are governed by private individuals serving as trustees in establishing a mission for the organization and in attempting to effectuate it over time, and because they are not creatures of government.<sup>31</sup>

On the other hand, the voluntary institutions are public in the sense that the community benefit standard overlays a requirement, which should be made more explicit today, that these institutions affirmatively strive to assess community need, and to undertake some objectively verifiable efforts to both meet those needs and to

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28. Bruce C. Vladeck, "Taxing Logic," PRESIDENT'S LETTER, United Hosp. Fund (April, 1991).

29. Anthony R. Kovner & Paul Hattis, "Benefitting Communities," HEALTH MGT. Q. (Winter, 1990).

30. IN SICKNESS AND IN HEALTH, *supra* note 11; Seay & Sigmond, *supra* note 14.

31. Garrow v. Elizabeth Gen. Hosp. and Dispensary, 79 N.J. 549, 557, 401, A. 2d, 533, 537 (1979); Guggenheimer, *supra* note 16.

involve the community in those processes.<sup>32</sup> Implicit also in such a requirement is a concomitant reporting requirement by which such institutions should disclose to the public all community benefit processes and activities, and the resources available and allocated towards such end.<sup>33</sup>

When added to the extant procedural requirements for tax-exemption already mentioned, these requirements go beyond just a more rigorous application of the IRS "organizational test,"<sup>34</sup> and cross over into the "operational test"<sup>35</sup> by setting observable operational criteria. But unlike outcome-mandate criteria, these standards would *not* tie the hands of hospital trustees and managers, and thus devoluntarize the institution. To the contrary, these would be more rigorous than current law, be consistent with the procedural nature of present criteria, and would interpret the community benefit idea, as it should be, in a manner that both promotes community service and preserves the fundamentally voluntary nature of the institutions.

Both the "market in altruism" or "donative theory," which result in nothing more than a public popularity contest, and the "relief of poverty" criterion, which dictates outcomes for governance and management, amount to nothing more than *substituted judgment* by lawmakers in place of the voluntary governors or trustees.<sup>36</sup> Once this occurs, the institution ceases to be voluntary in nature and loses its most essential attribute. In commenting on the status of existing law, Colombo and Hall note that "...yet everyone who now considers the issue, even the hospital industry, conceives that something more is required. The debate really turns on what that 'something else' is that hospitals should provide."<sup>37</sup> With this I wholeheartedly concur. However, the authors have just picked the

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32. Seay and Sigmond, *supra* note 14.

33. *Id.*

34. Treas. Regs. § 1.501 (c) (3)-1 (b). See also I.R.S. Pub. 557 (1991).

35. Treas. Regs. § 1.501 (c) (3)-1 (c) (1).

36. Although there may be weaknesses in the analogy, neither corporate law nor the Securities Exchange Commission seek to guarantee that a business make a profit, nor do they penalize them if they fail to do so. What those bodies of law do, however, is set some ground rules along the way, about how we expect the game to be played and what sort of structures and behaviors are and are not acceptable. Likewise, the rules for voluntary hospitals should not seek to prescribe their outcomes or their successes, nor to guarantee that they produce a certain result or penalize them through the tax code if they do not. Tax exemption criteria simply ought to provide the framework within which they may operate—and further, encourage the types of structures, organizational forms, and behaviors which we perceive to be beneficial to our communities.

37. See Colombo & Hall, *supra* note 16, at 31-32.

wrong fork in the road. The direction I point to is toward the qualitative or "process" standards referred to above.<sup>38</sup> The authors suggest that such standards have no eye toward the actual outcomes and that the approach would enmesh the Congress in a "metaphysical values debate" over the performance of the tax-exempt hospitals in relation with others.

By way of response I suggest that there is very little metaphysical about process criteria. The sorts of questions these criteria would ask are as follows: Does the hospital formally commit itself to service for a designated community, by means of a mission statement or other instrument? Has the hospital undertaken, either by itself or in collaboration with others, a health care needs assessment for the population within the designated community? Has the hospital, either by itself or in conjunction with others, set specific community health improvement goals for this designated population? Has the hospital developed—and annually reviewed and revised—a specific community benefit plan to effectuate these activities including any number of objectively demonstratable programs, such as special initiatives for the poor and other underserved individuals? Is there evidence in all of these hospital processes of community input and involvement? Does the hospital take a leadership role in pursuing community health objectives? Does the hospital regularly report on its community benefit activities and divulge the financial resources made available to do so? I would suggest that none of these questions are metaphysical and that all of them are more easily answered than the calculus required by the mathematical formulae proposed by Congressmen Donnelly or Roybal. They most certainly will produce a result more rational and substantive than one which would leave the metaphysical questions to Madison Avenue, which is what surely would result if hospitals were put on notice that it is their public image and popular perception which will determine their tax status.

As Vladeck and I have pointed out, *mission matters*;<sup>39</sup> however, process matters too. A community-serving intent, when coupled

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38. The only state so far to adopt legislation regarding the accountability of voluntary hospitals as to their community service performance is New York, where precisely the sort of process criteria for which I argue have been used. N.Y. State Pub. Health Law, 2803-1 (McKinney 1991). The similarity of these criteria to those being developed by the Hospital Community Benefit Standards Program, and to those adopted by both the Catholic Health Association and Voluntary Hospitals of America, may be the reflection of a trend toward a fairly broad consensus on this issue.

39. J. David Seay & Bruce C. Vladeck, "Mission Matters," in *IN SICKNESS AND IN HEALTH*, *supra* note 11, at 1, 22-34.

with certain reasonable safeguards as to the organizational structure or processes by which an organization is governed and managed, should provide that better understanding of “community benefit” that is so sorely needed in the current debate.